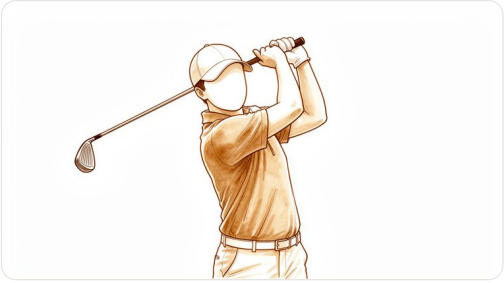
CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

REHABILITATION PROTOCOL

Medial Epicondylitis (Golfer's Elbow)



Golfer's elbow: wear-and-tear of the flexor-pronator tendons where they attach to the bony bump on the inner elbow (the medial epicondyle). The ulnar nerve runs just behind it.

Kieran Hirpara 4.0

This page guides your recovery from medial epicondylitis — commonly called **golfer's elbow** — under the care of Dr Kieran Hirpara at Mater Private Hospital Rockhampton. Most people recover fully without surgery, and the cornerstone of treatment is a steady, loading-based exercise program rather than rest. It begins with your home exercise program, followed by the structured clinical protocol written **for your physiotherapist or hand therapist** — bring this page or its PDF to your first therapy visit so your rehabilitation stays coordinated. Your therapist may adjust the plan depending on how your recovery progresses.

If you develop pins-and-needles, numbness or weakness in your little and ring fingers, let the rooms or your therapist know — the ulnar nerve runs right behind the inner elbow and sometimes needs separate attention.

What to expect

Golfer's elbow is a **wear-and-tear (degenerative) problem of the tendons** on the inner side of the elbow — the flexor-pronator tendons, which bend the wrist and turn the palm down, where they attach to the bony bump called the medial epicondyle. Despite the old name "epicondylitis", it is **not really an inflammation**; the tendon has become weakened and disorganised from overload. That is why the modern treatment is not rest and anti-inflammatories, but a graded program that gently **loads the tendon back to full strength**.

Recovery takes patience. Golfer's elbow is generally self-limiting, but it can take **6 to 18 months** to fully settle. The good news is that the great majority of people get better with a good conservative program and never need an operation. Surgery is only considered after at least **six months** of quality therapy has failed.

One feature that makes the inner elbow different from the outer (tennis) elbow is the **ulnar nerve** — the "funny bone" nerve — which runs in a groove immediately behind the medial epicondyle. Around half of people with golfer's elbow also have some irritation of this nerve, so your therapist will check it at each visit and may add specific nerve-gliding exercises.

CQ HAND + UPPER LIMB
Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au

Precautions and limitations

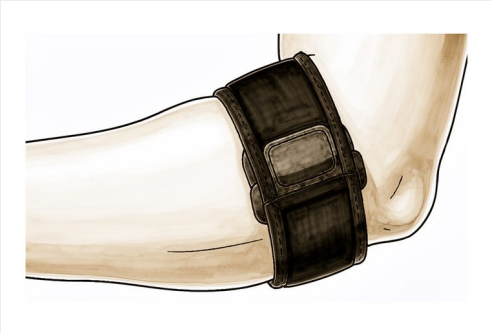
Do:

- Keep using the arm for normal daily tasks within comfortable limits.
- Modify, rather than completely stop, the activities that flare it up.
- Wear a counterforce brace over the forearm muscle during aggravating activity if it helps.
- Do your stretches and loading exercises regularly — consistency matters more than intensity.

Do not:

- Do not rest the elbow completely or put it in a cast — the tendon needs gentle load to heal.
- Avoid the heavy valgus-loading activities early on: golf, throwing (especially the cocking and acceleration phases), swimming and racquet sports, until your strength is rebuilt.
- Do not push any exercise into sharp pain, and do not push nerve glides into pins-and-needles or numbness.
- If your ulnar nerve symptoms (tingling or numbness in the little and ring fingers) get worse, ease back and seek review before progressing your loading.

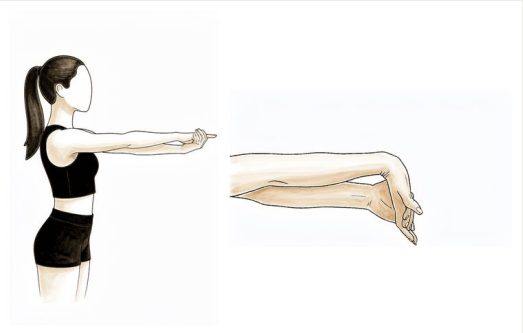
Your exercises



Counterforce brace

Wear the brace around your forearm a few centimetres below the inner elbow, over the muscle bulk — not over the bony bump itself. It should feel firm but not tight enough to make your hand tingle or go numb. Use it during aggravating activities (gripping, lifting, sport) in the early weeks, and wean off it as your symptoms settle.

During aggravating activity; wean as symptoms allow



Wrist flexor stretch

Straighten your affected arm out in front of you with the palm facing up. With your other hand, gently pull your fingers and wrist down towards the floor until you feel a comfortable stretch along the inner forearm. Early on, keep the elbow bent to about 90°; as you improve, do the stretch with the elbow straight. Hold without bouncing.

Hold 20–30 seconds, 3–5 times, 2–3 times daily

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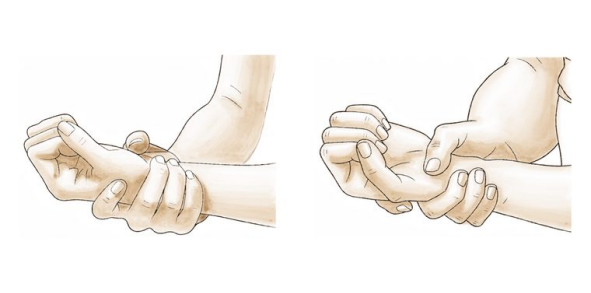

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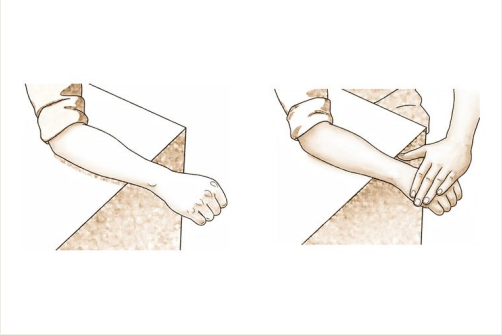
Pronator stretch

With your elbow tucked by your side, turn your palm to face the floor. Use your other hand to gently turn the forearm a little further into the palm-down position until you feel a mild stretch on the inner forearm. Keep it gentle and pain-free.

Hold 20–30 seconds, 3–5 times, 2–3 times daily



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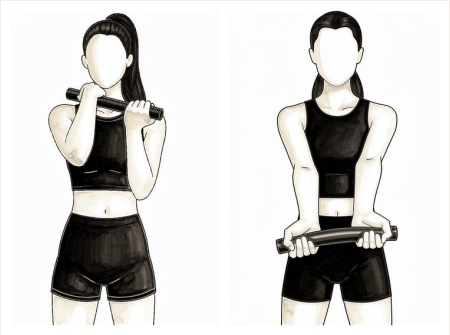
Wrist isometric (flexor) loading

Rest your forearm on a table with the palm facing up. Press the palm of your other hand against your fingers and try to curl your wrist up, but hold it still so the wrist does not actually move — a steady hold against resistance. This is an early-stage exercise to load the tendon gently and ease pain.

Hold 30–45 seconds, 5 holds, 1–2 times daily



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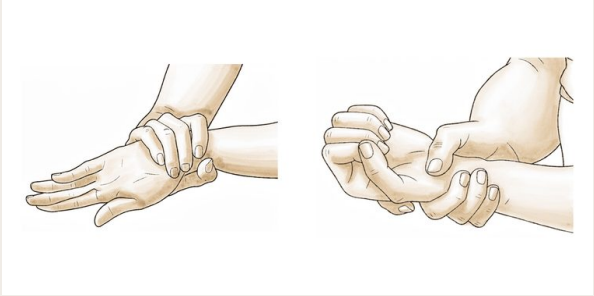
Reverse Tyler twist (eccentric flexor loading)

Hold a rubber exercise bar (FlexBar) in your affected hand with the wrist curled up (palm towards you), and twist the bar with your good hand. Bring the bar out in front of you, then slowly let your affected wrist uncurl in a controlled way over 3–4 seconds — your good hand does the twisting, your affected wrist does the slow controlled release (the 'eccentric' part). This is the key strengthening exercise for golfer's elbow and is introduced once early pain has settled (from about week 4).

3 sets of 15, once daily



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Forearm rotation

With your elbow tucked by your side, slowly turn your palm up towards the ceiling, then down towards the floor, keeping the elbow still. This keeps the rotating muscles of the forearm moving and loads the pronators gently as you progress.

10 times each direction, 2–3 times daily

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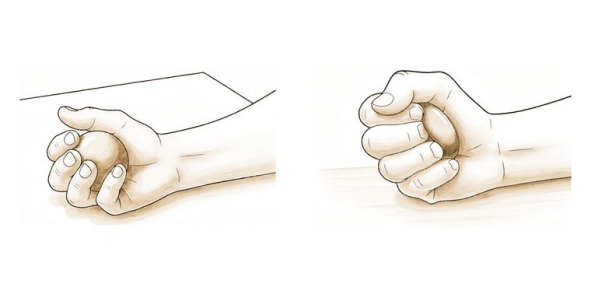

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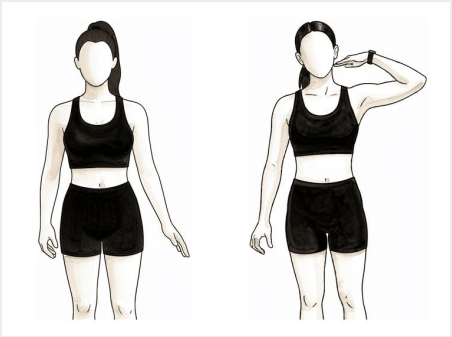
Grip strengthening

Squeeze a soft ball or therapy putty, hold briefly, then relax. Introduce this once your stretching and eccentric loading are comfortable — it builds the grip and forearm strength you need for daily tasks and sport. Stop short of sharp pain.

10–15 squeezes, 2–3 times daily



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Ulnar nerve glide

The ulnar nerve runs in a groove just behind the bony bump on the inner elbow, and is often irritable in golfer's elbow. To keep it gliding freely: make an 'OK' ring with your thumb and index finger, then bring it up towards your face so the ring sits around your eye, with the elbow bent and the palm towards you. Move gently in and out of the position. Do NOT push into pins-and-needles or numbness — back off if your little and ring fingers tingle, and tell your therapist or the rooms if nerve symptoms are getting worse.

5–10 gentle glides, 2–3 times daily

These are the exercises from your handout. Start them as guided by Dr Hirpara and your therapist. In the early weeks the emphasis is on settling pain, gentle movement and the isometric holds; the eccentric reverse Tyler twist and grip strengthening are added as you improve. The ulnar-nerve glide is included because the nerve is so often involved on the inner elbow – keep it gentle.

Your clinical protocol

The rest of this page is the clinical rehabilitation protocol. This section is to be provided to your physiotherapist or hand therapist. It is criteria-gated rather than purely time-based – progress between phases depends on meeting the goals listed, not simply on the calendar. **The ulnar nerve is screened at every visit** (Tinel's sign, subluxation), as roughly 50–60% of medial cases have concomitant ulnar nerve symptoms, which are the leading reason conservative care fails.

There are two pathways below: the **non-operative** program (first-line, for the great majority) and the **post-operative** program (for the minority who proceed to surgery after failing conservative care).

NON-OPERATIVE PATHWAY

Phase I – Acute / pain control (0–2 weeks)

Goals: settle pain; restore full unloaded range of motion.

- Relative rest and **activity modification** – use pain as the limiter; avoid immobilisation. Modify golf, throwing, swimming, racquet sports, weightlifting and repetitive gripping.
- Optional **counterforce brace** over the common flexor mass; a wrist splint may be used if acutely painful.

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- Pain-control adjuncts: ice, soft-tissue work / IASTM, gentle pain-free active range of motion (AROM), nerve glides.
- **Screen the ulnar nerve** (Tinel, subluxation).
- *Criteria to progress:* full unloaded AROM without pain; independent home program.

Phase II – Sub-acute / early loading (2–4 weeks)

Goals: begin flexor-pronator loading; address the proximal chain.

- **Isometric** wrist-flexor and pronator loading (light).
- Progressive **stretching** of the wrist flexors at 90° elbow flexion.
- **Proximal kinetic chain:** scapular stabilisers (serratus anterior, mid/lower trapezius) and rotator cuff – critical in throwers, where medial elbow overload is valgus-driven.
- *Criteria to progress:* full ROM maintained; tolerates the 90° stretch; ~70% of contralateral strength.

Phase III – Strengthening / return (4–6+ weeks)

Goals: restore load tolerance and return to function and sport.

- **Eccentric-concentric loading** of wrist **flexion** and forearm **pronation** – the medial analogue of the Tyler twist is the **"reverse Tyler twist"** (eccentric wrist flexion on a FlexBar). Combined eccentric-concentric loading is favoured; isometrics remain useful for early analgesia.
- Mobilisation-with-movement; progress stretching towards the elbow-extended position.
- **Grip strengthening**, then sport-specific loading; for throwers, an **interval throwing program**; plyometrics last.
- Wean the counterforce brace as the elbow becomes asymptomatic; address equipment and technique.
- *Return-to-sport criteria:* ~90% of contralateral strength, pain-free function, self-management.

POST-OPERATIVE PATHWAY (FLEXOR-PRONATOR DEBRIDEMENT ± REPAIR ± ULNAR NERVE PROCEDURE)

Surgery is reserved for the minority failing ≥ 6 months of conservative care. The open Nirschl-type operation debrides the pathological flexor-pronator origin and commonly repairs/reattaches it; the **ulnar nerve is assessed and protected**, with decompression or anterior transposition performed concurrently in a proportion of cases.

Phase 1 – Protect (0–2 weeks)

- **Posterior long-arm splint** (elbow + wrist) for **10–14 days**; sling for community use.
- Elevation and oedema control; finger/tendon-glide AROM; active shoulder ROM; gentle cervical AROM.
- *Precautions:* NO lifting, pushing, pulling or forceful gripping – protect the repair.

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Phase 2 – ROM restoration (2–6 weeks)

- At the ~2-week visit: suture removal; transition to a **neutral wrist orthosis** full-time (off for hygiene); Tubigrip at the elbow for swelling.
- Begin **AROM elbow** flexion/extension (2–4 wk), then **4-way wrist AROM + forearm rotation** and finger/thumb AROM (4–6 wk).
- **Ulnar nerve glides introduced at weeks 4–6** (the medial-specific addition).
- Scapular stabilisation (gravity-resisted). **No resistance strengthening until after 6 weeks.**

Phase 3 – Strengthening (6–12 weeks)

- Wean the orthosis as tolerated (night use may continue early on).
- **Progressive resistive strengthening** of wrist and forearm. No resisted supination/pronation early; begin lifting in **supination/neutral**, with **light pronated lifting from ~week 9**.

Phase 4 – Return to activity / sport (12–16+ weeks)

- Progress lifting in **all forearm positions** as tolerated; **full return to activity by ~12–16 weeks**; sport-specific / interval throwing program for athletes. Full recovery is commonly 3–6 months.

Ulnar nerve precautions: if an anterior transposition was performed, **limit end-range elbow flexion early** and progress nerve excursion gradually. Persistent or worsening ulnar symptoms warrant surgeon review before advancing loading.

Getting back to work and activity

How quickly you return depends on which pathway you are on and the demands of your job and sport.

Non-operative. You can usually keep working and stay active throughout, modifying the tasks that flare the elbow rather than stopping completely. Golf, throwing sports, swimming and racquet sports are eased back in during the strengthening phase, once your strength is roughly 90% of the other side and function is pain-free. Because golfer's elbow is self-limiting, full resolution may take **6 to 18 months** even though day-to-day function improves much sooner.

Post-operative. Light, restricted use begins early but heavier lifting and gripping are held back to protect the repair. Most people return to full activity by about **12 to 16 weeks**, with full recovery commonly taking 3 to 6 months. Throwing athletes follow a graduated interval throwing program before returning to competition.

Driving: avoid driving while you are in a splint or sling, or while the elbow is too sore to control the car safely. Resume once you are out of the splint and can move the arm comfortably, as confirmed at your review.

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After your protocol

This protocol works alongside the practice's general recovery advice — see managing post-operative pain, wound care and hand therapy basics. Golfer's elbow shares its loading-based approach with its outer-elbow counterpart, tennis elbow; ask your therapist if you would like the equivalent lateral epicondylitis guidance. Your ongoing recovery is guided individually by your physiotherapist or hand therapist according to how your elbow progresses.

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